DOCUMENT RESUME

ED 352 227 RC 018 877

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TITLE Therapeutic Uses of Adventure-Challenge-Outdoor-Wilderness: Theory and Research.
INSTITUTION Coalition for Education in the Outdoors, Cortland, NY.
PUB DATE 92
NOTE 15p.; In: Henderson, Karla A., Ed. Coalition for Education in the Outdoors. Research Symposium Proceedings (Bradford Woods, IN, January 17-19, 1992); see RC 018 876.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Adventure Education; Literature Reviews; Outdoor Education; Professional Training; Psychiatric Services; *Psychotherapy; Research Design; *Research Needs; Research Problems; *Theory Practice Relationship

ABSTRACT

This paper presents a critical review of literature concerning research with diagnosed populations who participated in outdoor learning experiences as part of psychiatric therapy. The paper proposes: (1) to clarify the definition of the psychotherapy related to adventure programs; (2) to develop specific training manuals that can be shared and tested using quantitative and qualitative methods; (3) to address issues related to teaching traditionally-trained psychotherapist to become experientially-based outdoor leaders and professionals; (4) to make research accessible through development of a database of theoretical information; and (5) to share what outdoor therapists do with traditional therapists through traditional psychotherapy journals and at regional and national conferences. Through research and practice, adventure therapy will realize integrity, credibility, and reliability in the field of psychotherapy. This paper includes a list of research conducted with different diagnostic populations since 1980. (LP)

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THERAPEUTIC USES OF ADVENTURE-CHALLENGE-OUTDOOR-WILDERNESS: THEORY AND RESEARCH

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Keynote Presentation

Therapeutic Uses Of Adventure-Challenge-Outdoor-Wilderness: Theory and Research

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One of the emerging theories of therapy that appeals to me as a psychologist has its roots in the work of Milton Erickson (1980) and is labeled "utilization." I believe the theory is very respectful of all persons whether they be patients or clients, normal or dysfunctional, acute or chronic, temporarily, or differently abled. The respect evolves from an attempt on the part of the helper o co-create a treatment plan with the person who comes to the therapeutic situation in order to facilitate solutions to real or imagined problems. Such an approach might utilize a person's past exposure with therapy to find out what did or *did* not work and utilize that information in mapping a way to health. The therapist might also plan a strategy that involves paradoxical directives or absurd tasks to utilize a client's resistance. Whatever the strategy, the therapist is open to assessing what the person brings to the environment where therapy takes place in order for a co-creation to be successful.

The goal of this presentation is to utilize my knowledge of diagnosed populations who participate in outdoor learning experiences as part of a therapy prescription and identify some adequately documented key work as well as recurrent and forthcoming findings.

In a quest to "walk my talk" or "practice what I preach," I have attempted to utilize expertise from past writers on outdoor learning experiences in order to co-create with them a list of what we know and what we need to know about my topic. I chose not to bore you with an evaluation of past research attempts that suffer from a lack of adequate control groups, follow-ups, sample sizes, or other threats to both internal and external validity. I believe writings by Bandoroff (1990), Burton, (1981), Ewert (1987, 1989), Levitt (1982), and Shore (1977) as well as others cover a substantial amount of information on research into outdoor pursuits that include references to therapeutic populations. The writings of Bacon (1983, 1987, 1988; Bacon & Kimball, 1989), Chase (1981), Gass, (1991), Kimball (1983, 1991), Haussman (1984), Roland, (Roland et al., 1987), Schoel, Prouty, & Radcliffe, 1988; Stich (1983; Stich & Gaylor, 1983), and Witman, (1989) have also contributed significantly to this field. These writings are highly recommended by those seeking such research evaluation. I have chosen to limit my review to the past decade including the reviews mentioned above and additional work drawn from recent (1980-1991) available abstracts, articles, and documents obtained from CD-ROM and DIALOG searches of ERIC, PsychLit, and Dissertation Abstracts International. I have also attempted to limit my search to empirical articles that specifically work with a population that would meet DSM-III-R (American Psychiatric Association, 1987) criteria or theoretical articles I judged to contribute to understanding or furthering the field of therapy in outdoor learning situations. I have also chosen to apply Kazdin's (1991) definition of psychotherapy to my reading of our field. He stated that:

> psychotherapy is ... an intervention to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and prosocial functioning. These ends are sought primarily through interpersonal sources of influence such as learning, persuasion, counseling, and discussion integrated into a specific treatment plan. The focus is on how clients feel (affect), think (cognition), and act (behavior) (p. 785).

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As most of you know, comprehensive searching of this field is difficult and I apologize at this point for intentionally or unknowingly leaving out or including an article that you feel is worthy or unworthy. My aim is to be as inclusive as possible. This paper may be more global than you are wanting, but it is my goal to try to work within a realistic boundary. I also recognize that having realistic and clear boundaries is a goal many of us as therapists have with the clients and families with whom we practice. By defining my agenda, I hope to make a contribution to the field.

Research Critique

The thrust of my article is to apply research critiques from the field of psychotherapy onto my topic area. For this I will make use of recent review work by Gelso and Fassinger (1990); Goldfried, Greenberg, and Marmar (1990); and Kazdin (1991). I wish to use selected recommendations they have made for research on psychotherapy as a guide to evaluate and advocate improvements in our field.

First, there are a variety of forms of what can be labeled as "psychotherapy." Our field also suffers from definition problems as others (Roland et al., 1988) have noted. The novice and experienced reader is faced with various terms such as adventure therapy (e.g., Gass, 1991; Stich & Senior, 1984), adventure-based counseling (e.g., Maizell, 1988; Shoel, Prouty, & Radcliffe, 1988), experiential-challenge (e.g., Roland et al., 1987), outdoor-adventure pursuits (e.g., Ewert, 1989), therapeutic adventure programs (e.g., Wichmann, 1991), therapeutic camping (e.g., Rice, 1988; Walton, 1985), wilderness therapy (e.g., Bacon & Kimball, 1989; Berman & Anton, 1988; Levitt, 1982), and wilderness-adventure therapy (e.g., Bandoroff, 1990) to name the primary labels attached to what many of us do. Our field also uses different environments such as camps or wilderness settings and activities such as traditional residential camp activities, rock climbing, cross country skiing, and ropes courses. It is even difficult to limit this field to what takes place only in the out-of-doors, since many writers, myself included, (i.e., Gillis & Bonney, 1986, 1989) are bringing activities from outdoor settings into traditional psychotherapy settings. But we should not be held up in settling on one name or label.

Ewert (1987, 1989) notes a "theme" of therapeutic intervention "subsumed" in research on outdoor pursuits. He, along with others, cited global findings such as improved self concept, social attitudes, and behavior along with reduced emotional problems as evidence of (implied therapeutic) effectiveness. However, there still does not appear to be one clearly defined and researched method of conducting psychotherapy in outdoor learning experiences, in wilderness-adventure settings, or in using adventure-based activities that can be assessed for effectiveness. To correct this problem, we need specific treatment manuals, such as those required in training grants by the National Institute of Mental Health (NIMH) (Goldfried, Greenberg, & Marmar (1990), to provide protocols of psychotherapy in outdoor adventure settings. To gain respect in the research field and also provide practitioners with "how-to-guides," these protocols need to spell out exactly what is done in outdoor therapy. Such guides will allow for replication with similar or different populations and can be assessed quantitatively for effectiveness. In addition, qualitative evaluation can offer an understanding of how these programs work with homogeneous diagnostic populations while being compared with: (a) no-treatment control groups, (b) traditional methods of working with similar populations, (c) alternative methods of doing the same thing, and (d) different personality types/experience levels of leaders, including both formally and on-the-job trained. If such training manuals are developed, they need checks and balances to insure treatment integrity that might be provided through supervision or video-taped sessions (Kazdin, 1991). Such specificity, coupled with research, may be able to (a) revitalize the experiential tradition of psychotherapy, which according to Goldfried, Greenberg, and Marmar is "either in danger of becoming extinct, or ... (of) being absorbed by other approaches" (1990, p. 666), (b) gain more recognition and respect among traditional psychotherapy researchers and practitioners, and (c)

contribute significantly to the advancement and integration of our field with traditional psychotherapy. It is difficult, however, to envision how such extensive training manuals will be developed and evaluated across populations and therapists unless some of our larger organizations (e.g., Outward Bound and Project Adventure) fund such an in-house endeavor or some person or team of persons is federally or privately grant funded to be able to afford the time and energy necessary to carry out such an enormous project.

Secondly, our field, like that of psychotherapy, has used (a) diverse measures (e.g., self-report and behavioral measures), (b) various environments and activities (Rohnke, 1984, 1988, 1989, 1991), and (c) different levels of participant functioning such as fully and differently abled (e.g., Ewert, 1989; McAvoy, Schatz, Stutz, Schleien, & Lais, 1989; Robb & Ewert, 1987; Roland, 1982); inpatient (e.g., Berman & Anton, 1988; Stich & Senior, 1984; Voight, 1988) and outpatient (e.g., Berman & Davis-Berman 1989) assessed at different times (pretest posttest, and follow-up) for different lengths of treatment (e.g., Bandoroff, 1990; Burton, 1981; Ewert, 1987; Levitt, 1982; Shore, 1977). As Kazdin (1991) noted, the use of different and multiple measures, at different times, for different definitions results in alternative outcome criteria to decide what indeed does work.

Randomized clinical trials comparing treatment and control groups or alternative treatments on outcome measures have dominated the psychotherapy research. Such research has continued to be controversial due to "no-difference" findings. This lack of difference may be related to poor statistical power due to small sample sizes and "weak" assessment instruments (Kazdin, 1991). This low power may account for how laboratory findings among volunteer (solicited) clients at major research universities differ from clinical field-based "impressions" of practitioners using "alternative" treatments who deal with clients who often solicit (are referred or mandated to) them(Goldfried, Greenberg, & Marmar, 1990). For traditional psychotherapy, the use of regression techniques for targeting treatment-relevant client attributes instead of analysis of variance research designs is suggested to move beyond the "no-differences" findings. More field based research is also called for to make laboratory findings more practically relevant.

Due to cost, time consumption, comparable outcomes of various treatments, and internal and external validity issues, such outcome research is slowly giving way to the study of process as it relates to outcome in psychotherapy. Even global meta-analysis has fallen by the way in psychotherapy research and is being reserved only for specific populations or treatment approaches. A focus on significant change events in psychotherapy and a data base for collecting results of therapy (as Ewert, 1987, 1989 suggested) across different therapists is currently seen as a more fruitful avenue for researchers to contribute to practitioners (Goldfried, Greenberg, & Marmar, 1990).

Another evaluation criteria we should consider is offered by Jacobson and Truax (1991). They coined the term "clinical significance" to describe the ability of an approach or model to impact an individual's level of functioning following treatment so that they would (a) fall outside of the range of dysfunction, (b) fall within the range of the normal population, and (c) be closer to the mean of the normal population than the dysfunctional one.

Research specifically on therapeutic populations in adventure-challenge-outdoor-wilderness programming is subject to many of the same criticisms documented for other populations. These are the general lack of randomization, the use of non-equivalent control groups and "in-house" evaluations, and the lack of adequate follow-ups, resulting in generally positive but contradictory findings such as changes in self-report measures but no-differences in behavioral measures (Bandoroff, 1990; Burton, 1981; Ewert, 1987, 1989). It would, however, be difficult to criticize our research for lack of a field base since it appears nearly all of it is conducted within the natural (outdoor) environment. We, like our fellow sojourners in traditional group approaches to counseling (e.g., Gelso & Fassinger, 1990) could be criticized for a narrow focus on outcome

measures and research designs that utilize t-test and ANOVA evaluations instead of regression models for predictors of success (Goldfried, Greenberg, & Marmar, 1990). Such models are beginning to emerge in recent dissertation work, (cf. Rice, 1988; Wichmann, 1990) where relationships between predictors variables and dependent variables has yet to be firmly established (cf. Gibson, 1981).

Our field could benefit from both a global and specific meta-analysis of existing research on diagnosed populations instead of the numerous annotated bibliographies mentioned by Ewert (1987, 1989). Such an analysis might add credibility to our field especially if augmented by Jacobson and Truax's (1991) clinical significance criteria. We could also benefit from using randomized treatment versus placebo controlled studies to identify how an approach works instead of whether it is effective as noted by Parloff (cited in Goldfried, Greenberg, & Marmar, 1990).

Thirdly, and most related to the goal of this paper, Kazdin believes the real question for psychotherapy research is best summed by a quote from Paul (cited in Kazdin, 1991) who asks "What treatment, by whom, is most effective for this individual (group/family in many of our cases) with that specific problem, under which set of circumstances?" (p. 786) The what question is difficult to answer due to the definition problem mentioned above. With respect to Bacon (1983, 1987, 1988, Bacon & Kimball, 1989), Gass (1991), Project Adventure (Shoel, Prouty, & Radcliffe, 1988), Roland (Roland et al., 1987) and Wichmann (1991), there still does not appear to be a clearly stated and consistently tested method of how to conduct psychotherapy in our field. Perhaps the models just mentioned might fit well into Bacon's (1987) division of three different adventure programming models: (a) "mountain speak for themselves", (b) "Outward Bound Plus", and (c) "metaphoric." But, as mentioned earlier, comparisons among well documented models need to be tested. One wonders, however, even if treatment integrity is insured, if such comparisons will only reveal the same "no-difference" results found in psychotherapy research (Gillis, 1986; Goldfried, Greenberg, & Marmar, 1990; Kazdin , 1991). Our focus should be on how they work and with whom.

The "by whom" question is also difficult since training manuals do not exist nor has any research been found that assesses therapist competency in our field by comparing experienced versus novice therapist or formally trained versus on-the-job/"naturally" trained therapist. My hypothesis, based on the experience of training traditional counselors and adventure-based counselors, is that our field would find, as does psychotherapy, that "some therapists are better than others - regardless of training" (Goldfried, Greenberg, & Marmar, 1990, p. 663). We need to test this hypothesis ourselves instead of just debating the needs and merits of traditional psychotherapy training as a prerequisite for doing psychotherapy outdoors.

The effectiveness for different individuals, groups, and even families with specific diagnosis, under different circumstances and environments, is probably the most interesting and most difficult question to many of us. As seen in Table 1, there have been numerous studies with different diagnostic populations since 1980 (although the preponderance of delinquent studies remains). We must note the addition of programs with couples and families in this table as well as diagnostic specific groups such as victims of rape and incest. The lack of repeated studies on similar populations, however, is also obvious from viewing the table.

Further reading will reveal that measurement continues to be focused on global outcome changes without looking specifically at the process of such change or the context in which the change occurred. As Ewert (1990) noted in "revisiting" self esteem in outdoor settings, rock climbers' feelings of self esteem related to climbing skills did not transfer to more global feelings of valuing themselves. He felt the findings were mediated by feelings of competence in self. However, the question remains whether global changes in self esteem or other commonly measured outcome attitudes in our field translate to a specific therapeutic context of persons in

various diagnostic categories, who may also be different (e.g., in gender, race, class, or national origin) than has been the norm for our field.

Table 1

Studies Done with Different Diagnostic Populations Since 1980

Author	Date	Diagnosis	Population
Banaka & Young	1985	Chronic Psychiatric Inpatient	Adult
Bandoroff	1992	Delinquent	Adolescents & their Families
Boudette	1989	Delinquent	Adolescent
Berman & Anton	1988	Inpatient Psychiatric	Adolescent
Callahan	1989	Delinquent	Adolescent
Clagett	1989	Delinquent & emotionally disturbed	Adolescent
Clapp & Rudolph	1990	Outpatient	Families
Creal & Florio	1986	Inpatient	Adolescents & their Families
Davis-Berman & Berman	1989	Outpatient acting out	Adolescent
Deal	1983	Alcoholics	Couples
Duhaime	1982	Learning-Disabled	Adolescent
Freed	1991	Emotionally-impaired	Adolescent
Freeman, et al.	1982	Behavioral problems	Children
Gass & McPhee	1990	Substance Abusers	Adolescent & Adult

Table 1 (continued)

Studies Done with Different Diagnostic Populations Since 1980

Author	Date	Diagnosis	Population
Gaus	1981	Delinquent	Adolescent
Gerstein & Rudolph	1989	Non-distressed	Families
Gibson	1981	Delinquent	Adolescent
Gillis	1986	Non-distressed	Couples
Goodwin & Talwar	1989	Incest victims	Adult
Kirpatrick	1983	Alcoholics	Couples
Gugino	1987	Delinquent	Adolescent
Kjol & Weber	1990	Sex offenders	Adolescent
Kuhn	1982	Behavior disorders	Adolescent
Mainell	1988	Delinquent	Adolescent
Mason	1980	Non-distressed	Couples
McAvoy . et al	1989	Fully & Differently Abled	Adult
McClung	1984	Inpatient psychiatric	Adult
Minor	1988	Delinquent	Adolescent
Nunley	1983	Delinquent	Adolescent
Nurenberg	1985	Borderline	Adolescent
Pfirman	1988	Rape Victims	Adult
Rice	1988	Delinquent	Adolescent
Sakofs	1991	Delinquent	Adolescent

Table 1 (continued)

Studies Done with Different Diagnostic Populations Since 1980

Author	Date	Diagnosis	Population
Roland & Hoyt	1984	Physically disabled	Adolescents & their families
Schwartz	1983	Emotionally disturbed	Children
Stich & Sussman	1981	Inpatient psychiatric	Adult
Walton	1985	Inpatient	Adolescent
Weeks	1985	Delinquent	Adolescent
West	1989	Emotionally disturbed	Children
Wichmann	1990	At-risk	Adolescent
Witman	1989	Inpatient psychiatric	Adolescent
Wright	1982	Delinquent	Adolescent
Ziven	1988	Inpatient psychiatric	Adolescent
Zwart	1988	Delinquent	Adolescent

More extensive and focused review studies are needed at the depth of Bandoroff's (1990) review of 42 studies on conduct disordered/delinquent populations. I would like to briefly touch on Bandoroff's major findings as an example of what can and needs to be done in our field. First, consistent support was found for:

1. Changing self perception of participants to become more realistic.
2. Changing social attitudes towards others to become more positive and increasing participant's sense of belonging.
3. Lowering recidivism rates despite definition problems among researchers as to just what constitutes recidivism.

Secondly, Bandoroff noted inconsistent findings among variables such as locus of control, problem solving, behavior change and durability of change. His review ended with many of the same recommendations made in this presentation including the need to know what is causing the therapeutic effects: program elements or instructor variables. I agree with Bandoroff that process

evaluation of the delinquent/conduct disordered diagnostic category is sorely needed in this field. Hopefully more researchers will build on Bandoroff's analysis and recommendations for this population and expand their work into specific adult diagnostic groups as well as populations such as couples, families, and the elderly.

Recommendations

My attempt at contributing has been to overlay criticism and forecasting in the field of psychotherapy onto our field. The results have been that although we may fall behind in sheer numbers of studies, many of the trends in psychotherapy research offer helpful suggestions to guide further research. My recommendations include the following:

1. Someone needs to conduct a meta-analysis on therapeutic aspect of adventure-challenge-outdoor-wilderness that includes the criteria of clinical significance along with traditional measures of effect size.

2. Instead of spending time agreeing on a particular term or phrase to describe what we do, let's put energy in writing specific how-to training manuals that can be shared, and tested using quantitative and qualitatively methods with research designs focused on multiple measures and predictor models. The models need to be tested across numerous homogeneous diagnostic populations and in multicultural settings to better understand their strengths (when indicated) and limitations (when contraindicated).

3. As one or more models emerge that show some research promise, training issues can be addressed to better understand how to teach traditionally trained psychotherapist to do whatever it is we do as well as how to ethically train experientially based outdoor leaders and paraprofessionals.

4. Our writing needs to be more easily available to one another through an agreement to share resources and reference one another. Perhaps a common accessible database of theoretical information will allow dissertations to move beyond traditional pre-post, treatment-control, outcome designs and offer more information on <u>how</u> and with <u>whom</u>, <u>what(ever)</u> we do, works.

5. Finally we need to focus on sharing what we do with traditional therapists in traditional psychotherapy journals and at the traditional therapists' regional and national conferences. Such sharing may lead to our theory, practice, and findings being cited more often (cf. in traditional reviews of drug prevention (e.g., Tobler, 1986) and the treatment of juvenile offenders (e.g., Basta & Davidson, 1988)).

Summary

Following the presentation of ideas from this paper, a discussion ensued over my recommendation that someone write down <u>exactly</u> how they conduct adventure therapy in order for others to replicate that method. The term "cookbook" was brought into the discussion to describe what some in the audience apparently perceived as being told <u>the</u> way to do adventure therapy as opposed to <u>a</u> way of conducting adventure therapy that could then be replicated in different parts of the country with different populations in order to test the efficacy of a model.

Building on the cookbook metaphor, some in the audience noted that a cook will closely follow a recipe until accomplished and then will deviate and experiment with ingredients to fit particular preferences and taste. Others wanted to know just what level of detail would be included in an adventure therapy "cookbook" and how one model could be appropriate to the nuances of different populations under different situations with different dynamics. A suggestion made from the audience that I feel was very practical in helping the replication issue asked that writers in our

field, often limited by journal editors to briefly describing their particular procedure, offer to provide the reader with a more detailed description of exactly what activities were done with the population as well as the type and nature of the group discussion that accompanied the activities or experiences.

Integrity , credibility, and reliability are the cornerstones for an effective therapeutic adventure program. It is my hope that this paper and the ensuing discussion will be "food for thought" (pun intended!) for more fruitful research and practice of adventure therapy.

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